

## Medical Loss Ratio (MLR) Requirements

The Dental Benefit Program (DBP) that receive capitation payments to provide core oral health benefits and services to Louisiana Medicaid members are required to rebate a portion of the capitation payment to DHH in the event the DBP does not meet the eighty five percentage (85%) MLR standard. This document describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due DHH, and 4) monetary penalties that may be assessed against the CNN for failure to meet requirements.

## Applicability

The requirements apply to Coordinated Care Networks who receive a capitation payment to provide Medicaid services.

## Definitions

**Direct paid claims** means claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this

**MLR reporting year** means a calendar year during which group or individual health insurance coverage is provided by an DBP.

**Unpaid Claim Reserves** means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year.

## Reporting requirements related to capitation payments and expenditures

(a) **General requirements** For each MLR reporting year, a DBP must submit to DHH a report which complies with the requirements that follow, concerning premium revenue and expenses related to Louisiana Medicaid enrollees (referred to hereafter as MLR Report).

(b) **Timing and form of report** The report for each MLR reporting year must be submitted to DHH by June 1 of the year following the end of an MLR reporting year, on Schedule AJ of the DHH DBP financial reporting guide.

### Newer experience

If 50 percent or more of the total capitation payment received in an MLR reporting year is attributable to new enrollees with less than 12 months of experience in that MLR reporting year, then the experience of these enrollee may be excluded from the MLR Report. If the DBP chooses to defer reporting of newer business, then the excluded experience must be added to the experience reported in the following MLR reporting year.

(a) **General requirements.** A DBP must report to the Department of Health & Hospitals total capitation payments received for Louisiana Medicaid and CHIP enrollee for each MLR reporting year. Total capitation payments means all monies paid by DHH to the DBP as a condition of receiving coverage for core benefits and services as defined in the terms of the contract for Medicaid and CHIP enrollees.

## Reimbursement for clinical services provided to enrollees

(a) **General requirements.** The MLR Report must include direct claims paid to or received by providers, whose services are covered by the contract for clinical services or supplies covered by the contract. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any experience rating refunds paid or received. Reimbursement for clinical services as defined in this section are referred to as "incurred claims."

(2) **Incurred claims** must include changes in unpaid claims between the prior year's and the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

(3) Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

(4) Incurred claims must include changes in other claims related reserves.

(5) Incurred claims must exclude rebates paid to DHH based upon prior MLR reporting year experience.

## Adjustments to incurred claims

(i) Adjustments that must be **deducted** from incurred claims:

- (i) Prescription drug rebates received by the DBP.
- (ii) Overpayment recoveries received from providers.

(ii) Adjustments that may be **included** in incurred claims:

- (i) State subsidies based on a stoploss payment methodology.
- (ii) The amount of incentive and bonus payments made to providers.

(iii) Adjustments that must not be included in incurred claims:

- (i) Amounts paid to third party vendors for secondary network savings.
- (ii) Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management.
- (iii) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance

analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

## Activities that improve health care quality

(a) **General requirements.** The MLR must include expenditures for activities that improve health care quality, as described in this section.

(b) **Activity requirements.** Activities conducted by a DBP to improve quality must meet the following requirements:

(1) The activity must be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

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(iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the nonenrollees.

(iv) Be grounded in evidence based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(2) The activity must be primarily designed to:

(i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

(A) Examples include the direct interaction of the (including those services delegated by contract for which the DBP retains ultimate responsibility under the terms of the contract with, providers and the enrollee or the enrollee's representative (for example, face to face, telephonic, web based interactions or other means of communication) to improve health outcomes, including activities such as:

(1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act.

(2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.

(3) Quality reporting and documentation of care in non-electronic format.

(4) Health information technology to support these activities.

(5) Accreditation fees directly related to quality of care activities.

(A) Patient centered education and counseling.

(B) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.

(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(1) The appropriate identification and use of best clinical practices to avoid harm.

(2) Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns.

(3) Activities to lower the risk of facility acquired infections.

(4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug

interactions.

(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

(6) Health information technology to support these activities.

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and oral health activities, include:

(1) Wellness assessments;

(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(4) Public health education campaigns that are performed in conjunction with Louisiana Office of Public Health or local health departments;

(5) Actual rewards, incentives, bonuses, (excluding administration of such programs), that are not already reflected in payments or claims;

(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and

(8) Health information technology to support these activities.

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology

(c) **Exclusions.** Expenditures and activities that **must not be included** in quality improving activities are:

(1) Those that are designed primarily to control or contain costs;

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;

(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d2, as amended, including the new ICD10 requirements);

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality;

(14) State and federal taxes and regulatory fees; and

(15) Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, upon adequate showing by the DBP that the

activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement.

## **Expenditures related to Health Information Technology and meaningful use requirements**

(a) **General requirements.** A DBP may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities that are designed for use the DBP, DBP providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services

(2) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, DBPs or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management. organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self management.

## **Other nonclaims costs**

(a) **General requirements.** The MLR Report must include nonclaims costs described in paragraph (b) of this section and must provide an explanation of how capitation payments are used, other than to provide reimbursement for clinical services included in core benefits and services ,and expenditures for activities that improve health care quality,

(b) **Nonclaim costs other.**

(1) The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation for clinical services to enrollees, or expenditures on quality improvement activities as defined in this Section.

(2) Expenses for administrative services include the following:

- (i) Cost containment expenses not included as an expenditure related to a qualifying quality activity.
- (ii) Loss adjustment expenses not classified as a cost containment expense. (iii), Workforce salaries and benefits.
- (iv) General and administrative expenses.
- (v) Community benefit expenditures.

## **Allocation of expenses**

(a) **General requirements.** Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit lines of business or products other than those being reported, including but not limited to those that are for or benefit self funded plans, must be reported on a pro rata share.

(b) **Description of the methods used to allocate expenses.** The report required in Sec. 158.110 of this subpart must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other nonclaims costs, to each health insurance market in each State. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

(1) Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the DBP should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.

(2) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.

(3) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

(c) **Maintenance of records.** The DBP must maintain and make available to DHH upon request the data used to allocate expenses reported under this Part together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the MLR Report.

### **Formula for calculating an DBP's medical loss ratio.**

(a) **Medical loss ratio.**

- (1) A DBP's MLR is the ratio of the numerator, as defined in paragraph
- (b) of this section, to the denominator, as defined in paragraph
- (c) of this section. .

(2) A DBP's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

(b) **Numerator.** The numerator of a DBP's MLR for an MLR reporting year must be the DBP's incurred claims, plus the DBP's expenditures for activities that improve health care quality

(c) **Denominator.** The denominator of an DBP's MLR must equal the DBP's premium revenue,

## **Sec. 158.240 Rebating capitation payments if the 85% medical loss ratio standard is not met**

(a) **General requirement.** For each MLR reporting year, a DBP must provide a rebate to DHH if the DBP's MLR does not meet or exceed 85 percentage requirement.

(c) **Amount of rebate.** For each MLR reporting year, an DBP must rebate to DHH the total amount of capitation payments received by the DBP from DHH multiplied by the required MLR of 85% and the DBP's actual MLR .

(d) **Timing of rebate.** A DBP must provide any rebate owing to DHH no later than August 1 following the end of the MLR reporting year.

(e) **Late payment interest.** An DBP that fails to pay any rebate owing to an enrollee or subscriber in accordance with paragraph "B" of this section or to take other required action within the time periods set forth in this Part must, in addition to providing the required rebate to the enrollee, pay the enrollee interest at the current Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the rebate, accruing from August 1.